

PHYSICIAN

Date Received by Board

**APPLICATION FOR REINSTATEMENT
TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM
FOR THE BIENNIAL REGISTRATION PERIOD 2011 - 2013**

License No. _____

NEVADA STATE BOARD OF MEDICAL EXAMINERS

File No. _____

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

(For Board Use Only)

Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

I hereby apply for reinstatement to active or inactive status, and enclose the appropriate fee as indicated below:

_____ REINSTATEMENT TO ACTIVE STATUS \$1,600.00
_____ REINSTATEMENT TO INACTIVE STATUS \$ 800.00 (Inactive reinstatement – No CME required)

NOTE: You must reinstate to the status you held at the time your license became suspended for non-payment.

You may pay by check, cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

Name: _____

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

NRS 630.267 (2) Biennial registration: Submission of list and fee; suspension and reinstatement of license; notice to licensee. (2) When a holder of a license fails to pay the fee for biennial registration and submit all information required to complete the biennial registration after they become due, his or her license to practice medicine in this State is automatically suspended. The holder may, within 2 years after the date the license is suspended, upon payment of twice the amount of the current fee for biennial registration to the Secretary-Treasurer and submission of all information required to complete the biennial registration and after he or she is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

- YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM*.
- YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM* IS PUBLIC INFORMATION.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of **AMA Category 1** continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form**. Submit your proof of completion of CME with your completed **APPLICATION FOR REINSTATEMENT TO ACTIVE STATUS REGISTRATION** form. (See last page of this form for CME statement.) Please note: CME are not required for Inactive Status Reinstatement.

2. If your name and/or address have changed, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, a copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name _____

Street _____

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email address _____

3. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, indicate the location of patient records below:

Name _____
 Street _____
 City _____ County _____ State _____ Zip _____
 Phone Number _____

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE	41 NEOPLASTIC DISEASES	81 PEDIATRIC, RHEUMATOLOGY
2 ADOLESCENT MEDICINE	42 NEPHROLOGY	82 PEDIATRIC, SURGERY
3 AEROSPACE MEDICINE	43 NEUROLOGY	83 PEDIATRIC, UROLOGY
4 ALLERGY	44 NEURO-OPHTHALMOLOGY	84 PEDIATRICS
5 ALLERGY/IMMUNOLOGY	45 NEUROPATHOLOGY	85 PHYSICAL MEDICINE/REHABILITATION
6 AMBULATORY MEDICINE	46 NEURORADIOLOGY	86 PREVENTIVE MEDICINE
7 ANESTHESIOLOGY	47 NON-CONVENTIONAL MEDICINE	87 PSYCHIATRY
8 BLOOD BANKING	48 NUCLEAR MEDICINE	88 PSYCHOANALYSIS
9 BRONCO-ESOPHAGOGY	49 NUTRITION	89 PUBLIC HEALTH
10 CARDIOVASCULAR DISEASES	50 OBSTETRICS	90 PSYCHOMATIC MEDICINE
11 CATSCAN/ULTRASOUND	51 OBSTETRICS/GYNECOLOGY	91 PULMONARY DISEASES
12 CHILD NEUROLOGY	52 OCCUPATIONAL MEDICINE	92 RADIOLOGY
13 CHILD PSYCHIATRY	53 ONCOLOGY	93 RADIOLOGY, DIAGNOSTIC
14 CLINICAL PHARMACOLOGY	54 ONCOLOGY, GYNECOLOGICAL	94 RADIOLOGY, INTERVENTIONAL
15 CRITICAL CARE	55 ONCOLOGY, HEMATOLOGY	95 RADIOLOGY, NUCLEAR
16 DERMATOLOGY	56 ONCOLOGY, RADIATION	96 RADIOLOGY, THERAPEUTIC
17 DERMATOPATHOLOGY	57 ONCOLOGY, SURGICAL	97 RADIOLOGY, VASCULAR
18 EMERGENCY MEDICINE	58 OPHTHALMOLOGY	98 RHEUMATOLOGY
19 ENDOCRINOLOGY	59 OTOLARYNGOLOGY	99 RHINOLOGY
20 FAMILY PRACTICE	60 OTOLOGY	100 SLEEP DISORDERS
21 GASTROENTEROLOGY	61 PAIN MANAGEMENT	101 SPORTS MEDICINE
22 GENERAL PRACTICE	62 PATHOLOGY	102 SURGERY, ABDOMINAL
23 GERIATRIC PSYCHIATRY	63 PATHOLOGY, ANATOMIC	103 SURGERY, CARDIOTHORACIC
24 GERIATRICS	64 PATHOLOGY, CLINICAL	104 SURGERY, CARDIOVASCULAR
25 GYNECOLOGY	65 PATHOLOGY, FORENSIC	105 SURGERY, COLON/RECTAL
26 HAIR TRANSPLANTATION	66 PEDIATRIC, ALLERGY	106 SURGERY, GENERAL
27 HEMATOLOGY	67 PEDIATRIC, CARDIOLOGY	107 SURGERY, HAND
28 HOMEOPATHY	68 PEDIATRIC, CRITICAL CARE	108 SURGERY, HEAD/NECK
29 HYPNOSIS	69 PEDIATRIC, EMERGENCY MEDICINE	109 SURGERY, MAXILLOFACIAL
30 IMMUNOLOGY	70 PEDIATRIC, ENDOCRINOLOGY	110 SURGERY, NEUROLOGICAL
31 INFECTIOUS DISEASES	71 PEDIATRIC, GASTROENTEROLOGY	111 SURGERY, ORTHOPEDIC
32 INFERTILITY	72 PEDIATRIC, HEMATOLOGY/ONCOLOGY	112 SURGERY, PLASTIC
33 INTERNAL MEDICINE	73 PEDIATRIC, INFECTIOUS DISEASES	113 SURGERY, THORACIC
34 LARYNGOLOGY	74 PEDIATRIC, INTENSIVIST	114 SURGERY, TRANSPLANT
35 LEGAL MEDICINE	75 PEDIATRIC, NEPHROLOGY	115 SURGERY, TRAUMATIC
36 MATERNAL/FETAL MEDICINE	76 PEDIATRIC, NEUROLOGY	116 SURGERY, UROLOGIC
37 MEDICAL ACUPUNCTURE	77 PEDIATRIC, OPHTHALMOLOGY	117 SURGERY, VASCULAR
38 MEDICAL ETHICS	78 PEDIATRIC, PSYCHIATRY	118 TOXICOLOGY
39 MEDICAL GENETICS	79 PEDIATRIC, PULMONARY	119 URGENT CARE
40 NEO/PERINATAL MEDICINE	80 PEDIATRIC, RADIOLOGY	120 UROLOGY

Code

Code

Primary Scope of Practice _____

Secondary Scope of Practice _____

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***All of the following questions refer to the preceding
24-month time period of the date of your
submission of this form or since your last renewal.***

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

**FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST
SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED
TO YOUR COMPLETED APPLICATION FOR REINSTATEMENT
TO ACTIVE OR INACTIVE STATUS REGISTRATION FORM.**

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☐ No ☐ N/A
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No ☐ N/A
4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? ☐ Yes ☐ No ☐ N/A
☐ Yes ☐ No
5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? ☐ Yes ☐ No
6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)
☐ Yes ☐ No
7. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ☐ Yes ☐ No
8. Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☐ No
9. Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ☐ Yes ☐ No

10. Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization? _____ Yes _____ No

11. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? _____ Yes _____ No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____ Yes _____ No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

OTHER STATES OF CURRENT OR PREVIOUS LICENSURE

List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice medicine in any state, territory.

State/Territory	License #	Date of Issuance	Dates of Practice

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

SAFE INJECTION PRACTICE ATTESTATION

Applicants must review guidelines of the Centers for Disease Control and Prevention concerning the transmission of infectious agents through safe injection practices:

<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html> - or - <http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf>

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

Applicant: _____

Date: _____

CONTINUING MEDICAL EDUCATION (CME) STATEMENT *(Inactive reinstatement – No CME required)*

Please place a check mark next to one of the following statements:

_____ (a) I was initially licensed in Nevada prior to or during the time period July 1, 2009 through December 31, 2009 and completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (20) hours of which were in my scope of practice or specialty;

_____ (b) I was initially licensed in Nevada during the time period January 1, 2010 through June 30, 2010, the second six months of the past biennial period, and completed a minimum of thirty (30) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and twenty (20) hours of which were in my scope of practice or specialty;

_____ (c) I was initially licensed in Nevada during the time period July 1, 2010 through December 31, 2010, the third six months of the past biennial period, and completed a minimum of twenty (20) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and eighteen (18) hours of which were in my scope of practice or specialty;

_____ (d) I was initially licensed in Nevada during the time period January 1, 2011 through June 30, 2011, the fourth six months of the past biennial period, and completed a minimum of ten (10) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics and eight (8) hours of which were in my scope of practice or specialty, OR

_____ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2009 through June 30, 2011.

■ **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS OR PROOF OF COMPLETION OF 1 YEAR OF RESIDENCY OR FELLOWSHIP TRAINING OBTAINED DURING THE BIENNIAL.**

■ **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

BY SIGNING ON THE SIGNATURE LINE BELOW:

- 1) I hereby represent that I am the person named in this application for reinstatement to active or inactive status registration of license to practice medicine in the state of Nevada and that all statements I have made herein are true;
- 2) I understand that this application for reinstatement to active or inactive status registration will be rejected if I have not placed a check mark next to (a), (b), or (c) under the child support statement section; and
- 3) I understand that this application for reinstatement to active or inactive status registration will be rejected as incomplete if I have not answered all questions thereon and/or attached thereto: (a) the appropriate copies of proof of continuing medical education (CME); (b) payment of the appropriate fee(s); and (c) written explanation(s) to any "yes" answer(s).

Date

Signature

(SIGNATURE STAMP IS UNACCEPTABLE)

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:

Nevada State Board of Medical Examiners

P.O. Box 7238

Reno, NV 89510-7238

or fax to:

775-688-2321

Please type or print legibly.

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

Phone Number: _____

Credit Card Number: _____

Expiration Date: ____ / ____
 (MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of \$ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____